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ABSTRACT

To increase political awareness and competence in the nursing profession, the papers in these proceedings identify political concerns affecting nursing and nursing education and explain how individuals and groups can become effectively involved in the political process. The proceedings contain: (1) "Update on National Nursing and Health Policy Issues," by Jo Eleanor Elliott, which provides a brief retrospective look at some pervasive and persistent issues in nursing; gives an account of the national efforts to address these issues; presents a report of current provisions for nursing activities; and previews prospective divisional activities; (2) "Legislators' Opinions about Nursing: Interviews with Wisconsin Members of the Senate Human Services and Assembly Health and Social Services Committee," by Rebecca S. Lake, which identifies the methods legislators use to obtain nurses' viewpoints on proposed health legislation; (3) "Overview of Methods for Achieving Successful Political Outcomes, with Examples of Strategies for Nurses," by Kathleen A. Michels, which outlines ways in which nurses may influence political decision making; (4) summaries of caucus sessions on issues related to nursing practice, education, community health, and licensure; and (5) "A Guide to Legislative Information." (RO)

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POLITICAL ACTION FOR PATIENT ADVOCACY

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MIDWEST ALLIANCE IN NURSING

FALL CONFERENCE

SEPTEMBER 1981

POLITICAL ACTION FOR PATIENT ADVOCACY

Proceedings of the Fall Conference

September 12, 1981
O'Hare Hilton Hotel
Chicago, Ilinois

Edited by

Barbara B. Minckley, D.N.Sc.
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Political Action for Patient Advocacy

PREFACE

The proceedings in this volume were presented at the Midwest Alliance in Nursing's Fall Conference held September 12, 1982, at the O'Hare Hilton Hotel in Chicago, Illinois. The theme *"Political Action for Patient Advocacy"* drew together nursing leaders who shared their expertise and advice with colleagues so that both individual nurses and the profession would increase political awareness and confidence in their ability to intervene in the political process. This is especially important when preparing for fiscally difficult times predicted for the '80's and to make certain that nursing service, education, and research will command significant support at state and federal level. It is equally important that nurses know effective strategies for bringing needed changes affecting their professional practice. Afternoon caucus sessions enabled conference participants to define issues and formulate specific recommendations and strategies for implementation. Regional sharing of concerns with ensuing agreement on actions to be taken and legislation to be supported lends both credibility and power to the recommendations emanating from the region.

The conference was designed to help participants:

Identify political concerns which affect education and nursing service in the Midwest.

Implement political actions which can effectively influence political decisions related to nursing.

Explain how an individual or group can effectively provide input into the development of legislation and become involved in this process.

Identify the image of nurses as political change agents.

The proceedings of the Fall Conference reflect MAIN's efforts to promote communication among its members for improved nursing practice and care.

THE SPEAKERS

The speakers at MAIN's 1981 Fall Conference, nursing leaders accomplished in their respective fields, brought energy and ideas to explicate the theme *"Political Action for Patient Advocacy."*

Jo Eleanor Elliott, BSN, MS, Ph.D. (Hon.), FAAN, was the keynote speaker. Ms. Elliott is Director, Division of Nursing, Department of Health and Human Services, in the U.S. Public Health Service, and Chairman of the Health Resources Administration's National Advisory Council on Nurse Training. Previously, she served concurrently as Director of Nursing Programs at the Western Interstate Commission for Higher Education (WICHE) and as Chief Executive Officer of the Commission's Western Interstate Council on Higher Education for Nursing (WICHEN).

She has had leadership roles as President of the American Nurses' Association, 1965-1968; Chairman of the Board of Directors of the American Journal of Nursing Company, 1972-78; and has authored many professional publications. Ms. Elliott has received honorary doctorates from St. Anselm's College and Boston University. Other honors include membership in Sigma Theta Tau and recipient of the National League for Nursing's Mary Adelaide Nutting Award.

M. Ethel Payne, RN, BS, MPH, is Chief, Health Manpower Branch and Regional Nursing Program Director, USDHHS, Region V, Health Resources Administration, Division of Resource Development, Chicago, Illinois. Her responsibilities include managing all activities and funding for Medical, Dental, Nursing, Associated Health and Public Health Education programs. Ms. Payne is a Fellow of the American Public Health Association. She assisted in developing a national program for coronary care units and training courses in cardio-pulmonary resuscitation and coronary care nursing. She also established an early Migrant Health Project in Virginia.

Ms. Payne represented the extension of federal leadership resources to the regional level. Coordination and planning for health resource development and utilization are accomplished more precisely through the regional offices. The regional office also interprets change in federal legislation and programs to those who require this information.

Rebecca S. Lake, RN, BSN, MSN, is Assistant Vice President for Nursing, Methodist Hospital, Madison, Wisconsin. Ms. Lake's master's degree thesis was "Legislators' Opinions About Nursing: Interview with Wisconsin Members of the Senate Human Services and Assembly Health Social Services Committees, 1980." As a recent guest lecturer at the University of Wisconsin-Madison's baccalaureate program, her topics included the Legislative Process in Wisconsin, Legislative Issues, Lobbying, and Nursing's Impact on Legislative Process. At the National League for Nursing's 5th Biennial Convention (Las Vegas, 1981) she submitted a resolution concerning nursing's political impact, collaboration with other health organizations, development of consumer advocacy role, and NLN-supported research and education to enhance Nursing's ability to participate in and impact upon the health care policy decisions at the local, municipal, and state levels. (It passed to become a 1981-83 resolution for the NLN.)

Kathleen A. Michels, RN, BSN, JD, is Staff Attorney and Legislative Liaison with the Wisconsin Nurses' Association, Milwaukee, Wisconsin. After working as an RN for number of years, Ms. Michels decided to attend law school to become a change agent and help alleviate potential problems in nursing by participating in the policy-making decisions and help them filter through the system to the staff nurse level. Her involvement in health legislation included testimony before the Wisconsin Senate Human Services Committee in support of nurse-midwife certification bills. Communicating the legal aspects of nursing to students and to members of the profession is another accomplishment. She has addressed University of Wisconsin Nurse Practitioner classes on legal implications of practice in Wisconsin, and pending health legislation; and she has been a member of a panel discussion presented for Wisconsin nurses regarding pending health legislation. In addition, Ms. Michels drafts model contract language for nurses' collective bargaining agreements, and counsels a health care union on current labor laws applicable to the health care industry.

CAUCUS LEADERS

In the afternoon, conference attendees chose one of the four caucus sessions best suited to their own professional interests: Practice Issues, Educational Issues, Community Health Issues, and Licensure Issues. The discussion leaders guided the sessions to identify the truly important legislative issues needing nursing intervention, support, or resistance. For each issue identified in the caucus groups, recommendations and/or strategies were suggested to be carried out by individual nurses, by State-level nursing organizations, and by MAIN at the regional level. Each caucus was instructed to summarize its findings. At the end of the sessions, Kathleen Michels synthesized the caucus reports and presented the information to the general session.

I. PRACTICE ISSUES: Linda M. Kielas, RN, BSN, Director, Department of Nursing, Illinois Hospital Association, Oak Brook, Illinois. Ms. Kielas monitors the impact of nursing-related activities of numerous state organizations and agencies (including Illinois state legislature), and has actively participated at the state legislative level on many nursing issues. During 1980, she developed a nationally known nursing-career education program. She has been responsible for the development of a statewide network of patient education coordinators who serve as resources to other coordinators in their region. She has assisted both the Illinois Commission of Critical Health Issues and the National Commission on Nursing in their projects to identify nursing issues and develop programs to resolve emerging problems. With Susan Geiersbach, and Ann Kobs, she implemented and published a survey report on nursing resources in Illinois.

II. EDUCATIONAL ISSUES: Helen K. Grace, BSN, MSN, Ph.D., FAAN, Professor and Dean, College of Nursing, University of Illinois at the Medical Center, Chicago, Illinois. Dean Grace has published extensively primarily in the field of psychiatric and family nursing. In 1977, she received Loyola University's Alumna Award for devoted services and dis-

tinguished contributions to Loyola and the Chicago community. Her professional activities include serving as Treasurer and member of the Program Committee and Governing Board of the American Academy of Nursing, 1979-80; Member of the Board of Directors of the National League for Nursing, 1979-83. Her research areas include "Socialization into Adult Family Roles: Longitudinal Study of the Development of Families"; "Defining Illness: Child-Family-Nurse Interaction"; "Productivity and Job Satisfaction of Doctorally Prepared Nurses"; and "Organizational Processes: Nurses' Preceptions of Their Work Situations." She authored the highly successful regional project for Nurse Faculty Research Development in the Midwest, a three year special projects grant from the Division of Nursing, 1978-81.

III. COMMUNITY HEALTH ISSUES: Carolyn E. Littlejohn, RN, BSN, MSN, Director of Education, Visiting Nurses' Association, Milwaukee, Wisconsin. Her responsibilities combine administration of a federal grant to train home health aides in a 10-county area of southeastern Wisconsin; and developing an Attenddant Training Curriculum and a Disabled Consumer Curriculum for the Southeastern Wisconsin Council for Independent Living. As Assistant Professor at the University of Wisconsin-Oshkosh (1967-72), she was the course chairperson for "Fundamentals of Nursing" and "Advanced Medical-Surgical Nursing." She also initiated a committee to establish university policies and procedures for the conduct of research involving human subjects. Papers published include "From Staff Nurse to Supervisor: A Plan of Development," and "What New Staff Learned and Didn't Learn." (Both in Nursing Outlook).

IV. LICENSURE ISSUES: Shirley A. Ross, BSN, MPH, Associate Professor, Indiana University School of Nursing; Member, Indiana State Board of Nurses' Registration and Nursing Education, Indianapolis, Indiana (President 1975-79; Hearing Officer 1979-80; presently chairperson of two Board committees). Professor Ross has received many honors including the Nurse of the Year award from the Indiana Citizen's League for Nursing and the All State Foundation, 1977; in October 1970, she was elected a

fellow 1975-80, she served on the National Accreditation Board of the American Nurses' Association. She is a past Treasurer of the Indiana Joint Practice Commission for Nurses and Physicians. She was the Principal Investigator and Director of the Family Nurse Practitioner Program (PRIMEX), of the Bureau of Health Services Research and Evaluation, DHEW. Her publications include "The Clinical Nurse Practitioner in Ambulatory Care Services," (Bulletin of the New York Academy of Medicine), and "Training the Family Nurse Practitioner," (Hospitals).

Annette Scheffel, RN, MSN
Chair
Program Committee
Midwest Alliance in Nursing

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Introduction of Jo Eleanor Elliott

First, permit me to bring you the latest news concerning Region V. Many of the Region's categorical programs will be funded through block grants next year. This means that funds will be given to the States which, in turn, will have control over which programs will receive funds. However, the Division of Nursing, which is within the Bureau of Health Professions, will not receive a block grant. At present, the program has authorization but no appropriations, so it remains to be seen what will happen. The Division of Nursing serves as the principal focus for nursing in the federal government with regard to nursing education, research and practice. It provides leadership for planning, coordinating, evaluating, and sharing the development and utilization of the nation's nursing resources.

Region V's role is an extension of the Division of Nursing whose purpose is to serve the six States of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. MAIN's seven other states are located in Regions VI, VII, and VIII. We try to keep tuned to other programs within the Department of Health and Human Services (which is not always easy) for the purpose of referring people to programs with funds for nursing. We also act as a resource to other programs in the regional office.

Introducing Jo Eleanor Elliott is an honor. In the short amount of time available today, only highlights of her professional career may be mentioned. Jo Eleanor was appointed Director of the Division of Nursing on July 1, 1980. Before this, she served concurrently as director of nursing programs at the Western Interstate Commission for Higher Education (WICHE) and as chief executive officer of the Commission's Western Interstate Council on Higher Edu-

cation for Nursing (WICHEN). Before joining WICHE, she taught in the School of Nursing at the University of California at Los Angeles.

Jo Eleanor received her bachelor of nursing degree from the University of Michigan where she taught in the School of Nursing for five years. She received her masters degree from the University of Chicago.

An active participant in professional organizations, Jo Eleanor served as president of the American Nurses' Association from 1964-1968; chairman of the Board of Directors of the American Journal of Nursing; and a member of the Board of Directors of the International Council of Nurses from 1965-1969. Her honors include membership in Sigma Theta Tau, recipient of the National League for Nursing's Mary Adelaide Nutting Award, and several honorary doctorates. She is a fellow of the American Academy of Nursing and the author of many professional publications.

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UPDATE ON NATIONAL NURSING AND HEALTH POLICY ISSUES

Jo Eleanor Elliott, BSN, MS, PhD (Hon.), FAAN
Director
Division of Nursing
USDHHS
Washington, D.C.

Political Action for Patient Advocacy

Update on National Nursing and Health Policy Issues

JO ELEANOR ELLIOTT, BSN, MS, PhD, (Hon.), FAAN
Director, Div. of Nursing, USDHHS, Washington, DC

Introduction: Importance of Federal, Regional, and State Roles

MAIN's development has been followed with great interest. As has been demonstrated by the Western Council on Higher Education for Nursing (WCHEN), much can be accomplished through regional collaboration and cooperation. Certainly, MAIN has moved forward differently from the other regional groups, but at the same time MAIN may have moved in a more certain direction. If MAIN can move toward selfsufficiency, and not have to rely on a board's decision to allocate money to operate each year, then programming and long range planning may proceed with more certainty. The organization has a better opportunity to decide what it can do for itself, and what outside resources are needed. It will be of primary importance that MAIN does what it can for itself.

Since 1979, my role has changed enormously. As Director of the Division of Nursing, in spite of the present economic pressures, I intend to be as productive as possible for the length of time that I am there, however long that may be. I do not anticipate that I will be "RIFed," but will gladly explain the current implications of Reduction in Force (RIF) to anyone who may be concerned about it. I have enjoyed being at the Division and I think our staff is committed to carrying out its functions and programs. Ethel Payne, Nurse Consultant for Region V, is an example of the high-quality personnel serving the Division of Nursing in the ten regional offices around the country. One of my commitments to the Division has been to strengthen the relationships between the Division and the regional staff. In the past, as Program Director for WCHEN, I have worked closely with the consultants in Regions VIII, IX and X. I realized then that the Division needed to make a greater contribution to the work to be done. Now that I am at

at the Division, I think we have strengthened those relationships and I look forward to working even more closely with the regional offices.

Obviously, there are many concerns about nursing and health policy issues, several of which are receiving media coverage. Recently, CBS presented a special one-hour program on nursing; the August 24, 1981 Time magazine ran an article called "Florence Nightingale Wants You," and ABC World News Television is planning a series. Daily newspapers throughout the country contain articles about nurses, the nursing "shortage", and nurses' strikes, while the shortage of nurses continues to become more acute. Thus, your discussions this Saturday, September 12, 1981, are very important in view of the new changes at the federal level; the block grants, and particularly what one does to influence the distribution of block grant money; and many other issues that need to be addressed at the regional, state, and local levels.

This presentation will cover four areas: (1) a brief retrospective look at some pervasive and persistent issues; (2) an account of the national efforts to address the issues; (3) a report of current provisions for nursing program activities; and (4) a preview of prospective Divisional activities. Following this, there will be discussions of your interests and concerns.

Today's Nursing Problems--A Continuation of Yesterday's

We all need to be aware that federal agencies and departments are part of the executive branch of government. That means the party in the White House determines the parameters and the thrust of the programs. You recall the expression: "The executive branch proposes and the Congress disposes." You need to be aware of the separation of duties and responsibilities of the executive, legislative, and judicial branches; especially when dealing with any federal representative, because these individuals are representatives of the administration and not of a separate or independent agency.

Recently, in the Division of Nursing, we had occasion to look at the classic Surgeon General's Consultant Group on Nursing Report, Toward Quality in Nursing, which was published in 1963. A review of this report suggests a striking similarity between issues and recommendations identified in 1963, and the same issues which are now a matter of public concern and spirited debate. This should not be surprising because the issues addressed by the Surgeon General's Consultant Group are long term. You must remember that scant prior attention had ever been given to nursing. In the 20 years since that report, the degree and amount of federal support could hardly be expected to solve problems that were well entrenched; and especially not during the concurrent period of fundamental changes in society, in the health care delivery system, and in the profession. In 1963, then as now, hospitals were giving increasingly complex care to a greater number of patients. Skilled nursing homes were growing in number; communities were acutely aware of the need for new and expanding programs for health promotion, disease prevention, and care of patients in their homes. Then, as now, in many institutions throughout the country, the quality of care suffered as inadequately prepared or over-burdened nurses were called upon to provide service beyond their capacity. Then, as now, there was concern about making the best possible use of the skills of nurses already in the work force; and the need for innovative approaches to staffing that would increase productivity and improve care in all practice settings. Then, as now, too few nurses had sufficient educational backgrounds for positions of leadership as teachers, administrators and expert clinicians.

Called for as well was the need to stimulate the conduct of studies focusing on clinical nursing practice and research to expand the scientific base of nursing knowledge. These basic themes, present in the 1960's, provided the impetus that launched the Surgeon General's Consultants' Group on Nursing to study the issues and make recommendations for resolving them. We are still at work on these same issues in the 1980's. The paradox is that while progress is being made, the problems seem to be expanding at an ever more rapid rate. Recommendations in response to the concern expressed in the Surgeon General's report in 1963, resulted in the Nurse Training Act of 1964, the first comprehensive piece of legislation enacted in support of nursing. How-

ever, not all of the recommendations from the Surgeon General's Consultant Group were included in the Act, such as funds for planning for recruitment, and for research.

National Efforts to Address the Issues

As to today's program, as you know, the prolific construction of health care facilities that took place in the 1960's and early 1970's, has subsided now. In 1968, 1971, 1975, and 1979, the nurse training authorities were extended, changed, or amended in response to changing needs and federal priorities. Legislation reflects the priorities either of the administration in power or the Congress--sometimes a combination of both or a negotiation between the two. From 1965 through 1980, the federal investment in nursing education has amounted to more than one and a half billion dollars, estimated to be 10% of the total expenditure for nursing education.

There is no question that federal support has served as a major catalyst to increase the supply of nurses and improve the quality of educational programs. Considering the issues and the increasing constraints on the dollars available for both health and education, it is important to keep in mind what may be termed "reality information." In the field of nursing today, people talk about the "shortages," nurses who drop out of the profession, nurses who choose not to work, and those who leave the profession and move into some other occupation. The truth of the matter is that we have more registered nurses today than we have ever had before. The number of nurses licensed to practice is greater than it has ever been in the past. The supply has risen steadily both in absolute numbers, and in relation to the increase in the total population. That is, the nurse-to-population ratio has increased remarkably. However, the increase in number does not address factors such as the distribution of nurses in relation to the levels and kinds of skills needed for certain areas and for certain populations, e.g., the elderly.

The proportion of licensed nurses participating in the labor force is greater now than ever before. The rate for nurses in 1977, the latest

year for which data are available, are 70%. That is, 70% of all nurses licensed to practice were working. There is a problem, however, in that nurses work parttime at a slightly higher rate than other women workers. One way to expand the capacity of the nursing force would be to get more nurses to convert from parttime to fulltime, or more parttime nurses to increase their number of working hours. Employers need to keep this in mind. The rate of unemployment among nurses is very low. Few nurses are out of work and looking for jobs; in fact, more nurses are working in hospitals than ever before. The number of fulltime nurses in community hospitals grew from approximately 370,000 in 1972 to nearly 560,000 in 1979--a big difference in the number of working nurses. These figures only describe the situation in hospitals. There are many other settings in which the nurse supply continues to be critical. Nurse staffing ratios in nursing homes have remained fairly static; and that, too, should tell us where some attention and concern need to be addressed.

Current Provisions for Program Activities

Current national efforts are continuing the work of studying nursing issues which need to be examined. National health policy issues are being formulated, too; however, most of my comments will be directed to the nursing issues. First, every two years, a congressionally mandated report on nursing is sent to the Congress from the Secretary of DHHS. The report, describing the supply, the requirements, and the distribution of nurses, is prepared in the Division of Nursing. This year, Mrs. Gretchen Osgood carried the primary responsibility for preparing the report. The report brings up-to-date the projections on requirements for nurses through 1990. The supply of nurses required and the projections of those requirements are determined using two different modeling approaches. One basic model evolved out of what was called the WICHE State model; the other is a straight line projection based on a model of historical trends. The recommendations in the third report to the Congress cannot exceed the parameters of the President's 1982 budget request. The recommendations deal with Advanced Nurse Training, Special Project Grants and Nurse Practitioner Grants three items in the President's 1982 budget. That report is due approximately October 1, 1981.

Maintaining adequate staffing in the Division of Nursing is going to be problematic. You have heard about the current reduction in force in the federal government, and it is real. The government does not guarantee a job for everyone, even those who have been on board for awhile. The number designated for the Division of Nursing is not known at this time. A wide range exists of possible "bottom line" figures!

The peer review process is a very healthy process which has been established over the years. It is one in which all program proposals submitted for federal funding are reviewed, and recommendations are made for either approval or disapproval. If approval is recommended, a priority is set for each proposal. Then the second level of review is performed by the National Advisory Council on Nurse Training. In this review, Division staff may raise questions concerning aspects of the proposal. A council member may request a special review for a particular proposal. Split votes from the first level committee's review are adjudicated. However, staff do not act as the quality evaluators for proposals, especially because staff give proposal consultations; and therefore they would be in a situation of conflict of interest if they were to evaluate the proposals as they come in. For greater economy, the Division may have to reduce the number of review cycles during the year. At present, there are three each year that involve incoming proposals, review committees, and the National Advisory Council. The number of cycles will be reduced before any consideration of eliminating the plan is undertaken. Of course, health care issues must always be addressed with attention to available funds and their allocation. This being the case, it is certain that the competition for scarce dollars will intensify. Competition may be between health and education, or between health and anything else at the federal level; and the same competition is likely to occur at the state level.

For whatever reason, education does not appear to have the aura in most states today that it had 10 to 15 years ago. There was a day when higher education got most of what it wanted from its state legislators. That day seems to be gone for education, including nursing education. Nursing is vulnerable, because it does not have the clout in many places that other disciplines have. Total resources allo-

cation at the local, state and federal levels will be increasingly competitive based on priorities at each level. To what extent then will society assume the need to make health care a priority? Eventually society will have to decide.

Preview of Prospective Trends

The problems of maldistribution and possibly the ineffective use of health professionals, including nurses, are pervasive and perennial. Some proposed that there is a rapidly approaching surplus of physicians. Already, in some places, this has resulted in physicians beginning to focus on nursing privileges: for example, at a Washington, D.C. hospital, physicians wanted to delete nurse midwives' privileges for practice. There are states in which physicians are now looking more critically at the nurse practitioner regulations so recently put in place during the 1970's; and there are some states in which physicians are suing nurses for violating the state's Medical Practice Act. Physicians are accustomed, even trained, to expect their opinions and decisions to prevail over others'. As nursing becomes competitive with medicine, it is important to look at how nursing differs from medicine. One of the provocative problems for medicine has been that nursing launched its nurse practitioner movement to "extend" physician services, or to take on some of the health care responsibilities that physicians have traditionally carried. This has served to confuse important legal issues regarding what is medicine and what is nursing. As a result, nursing has to create and defend its distinctive role and make clear the difference between nursing and medicine.

One of the operational concerns of all of us is unity. If there is one single factor that will make the most important difference for nursing advances within the next five years, it is unity. Unfortunately, unity among nurses appears to be diminishing rather than increasing. In the current politico-economic competition, nurses will have to be united at the State level to be able to get an equitable share of the block grant funds. To the extent that nurses are not united, nursing will receive fewer dollars, and the health care concerns of people will not receive the monetary support needed.

You need to plan now for the building of coalitions. For example, what kind of coalition can (or should) you build: with medicine? with hospital associations? with consumer groups? with the Association of Retired Persons (which incidentally has approximately 15 million members)? Such coalitions need to be formed to increase nursing's clout. During these next five to seven years, nursing will be tested in the area of unity. In the present projection, there will likely be some funds for nursing at the federal level. The federal government will maintain its focus on nursing even though it may be decreased for awhile; and it is probable that health care concerns will prevail in this country. Our society will not abandon its concern for the nation's health. Let us now turn to your specific questions about the Division of Nursing and the issues that have been raised affecting the future of nursing as a concern of federal and state government.

Questions from the Audience

I would like to know your opinion relative to how long Medicare funds will be available to reimburse service institutions that provide nursing education (diploma) programs in such a seemingly abundant amount, and used for direct pass-through of 'in hospital' nursing education costs?

I do not know the answer to that. Our Division of Nursing is not involved with Medicare and Medicaid funds, and so I cannot answer this very important question. This is an issue that others on the outside are going to have to address. I think this is an issue that will be looked at more carefully and critically as Medicare and Medicaid evaluate their costs. You are aware that Medicare and Medicaid funds are used for medical education in intern and residency programs; and so unless you wish to make a separate case for nursing, hospitals will continue to receive these funds for their diploma nursing programs.

I would like to ask two questions: First, what is the proportional amount of money that you have for contracts?

We do not have a set proportion for contracts. We have sent forward our contract plan for Fiscal Year 1982. We will fund no new contracts. It is my viewpoint that unless there is an issue that the Division is very concerned about, then the allocated nursing funds should go for grants rather than contracts.

I agree with that. However, do you welcome suggestions for contract RFP's?

Absolutely.

I wanted to comment that years ago from the earlier Surgeon General's report, nursing profited tremendously by the statement advocating that the research groups be required to have people with research training. I would hope that this would be reiterated continuously as this report is being looked at and maybe updated. I think it is deplorable that numbers of people going on for doctorates are not too concerned about the kind of research training they receive; therefore, when they take positions in academe, they really cannot supervise students in the conduct of their research which means a waste of resources; and worse, a loss of quality in the education the graduate students receive. I think it is partly because too many gaculty acquired their own doctoral preparation in education as opposed to acquiring it in the kinds of basic disciplines that include rigorous research training, and I am, of course, including good solid nursing doctorates, too. But unless nurses see to it that their doctorates include good research training, we are just wasting resources. I hope that this report will reemphasize that.

I am not certain which report you are referring to.

You mentioned the Surgeon General's report of 1963.

We are not updating that report. The report to the Congress I talked about is the DHHS Secretary's report to the Congress. It contains information provided by the Division of Nursing on the supply, requirements, and distribution of nurses as mandated by the Nurse Training Act of 1975. It does not address research since research authorizations are not included in the Act.

Are you going to address the education part?

It will address Advanced Nurse Training; it will not address research per se. You will find important recommendations about research in the AHA's Commission on Nursing report.

The appropriations legislation has been marked up by the House Committee on Appropriations. It now has to go to the Senate committee.

I do not know what the schedule is for the Senate committee, but I would urge people to get in touch with members of that committee and get them to support a level of funding commensurate with the program approved in the authorization. Concerning the research legislation, we have asked for an increase in the amount of money for nursing research: for research grants, fellowships, and pre-doctoral fellowships. People here need to do the same. Unfortunately, there is not very much time, because I understand that they are moving rapidly to mark up the Senate bill.

It is true that there is no set limit for funds allocated for nursing research. However, in the past years nursing has had $5 million for research support and $1 million for pre-doctoral fellowships. But I would say that we have unfunded research grant projects on hand, and unfunded predoctoral fellowship applications.

I will respond to one other comment you made. I realize that the pre-doctoral fellowships touch only a small number of nurses going for doctoral study, but very few fellowships coming through now are in the area of education. I would say that about half are in nursing programs and the other half in disciplines related to nursing such anthropology, physiology, and sociology. On the list that I saw the other day, I think there was only one in higher education. That is a shift in terms of where doctoral nursing study is headed, and the areas of research concentration for nurses seeking doctoral preparation.

I am glad to hear that, but I happen to know personally of many people that I see going on to doctoral study without appreciating the need for good research training. Many of these nurses are going on to education. I would like for us to help to show them the way, if you will.

To reiterate, I think federal funds are now going for training of nurses in the areas that provide rigorous research preparation.

You commented that bedside care is a priority of this administration. Were you talking about the entire administration or DHHS, or the Division of Nursing?

The whole administration. It is of special interest to Dr. Edward Brandt, the Assistant Secretary for Health.

When you were quoting the statistics of an overall increase of nurses in relation to the population, did that statistical report also look at the increase of nurses in relation to the number of hospitals; that is, whether there were the same number of hospitals, and whether there were additional beds in those hospitals?

You will be interested in the AJN article by Evelyn Moses and Aleda Roth (1979) in which these authors state that, even taking into account the effect of increased acuteness of care, the effect of patients' shorter stays in the hospital, and the increased number of available hospital beds, there is still an overall increase of 18% more nurses working in hospitals and available for hospital service since 1977. So they believe that there is an absolute increase in numbers of nurses and in the amount of nursing time available to patients, but I am not certain about the parttime consideration. One of their recommendations is that the hospitals and communities should look critically at the number of beds they have, and possibly cut back that number.

One of the things that this administration is saying is that there are some kinds of nursing shortages in some places. The previous administration, Carter's, said there was "no shortage," period. We do not have documentation that supports the belief that there is a shortage in the aggregate number of nurses. But it is clear that there are shortages by geographical areas and by levels of nursing staff. At present, nursing homes do not get reimbursed by Medicare for nurse practitioners, and so most do not hire geriatric nurse practitioners, although this specialized group could probably move patients from a custodial to a more therapeutic and rehabilitative environment, and get some of those people back to their homes.

On the other hand, filled beds make hospital administrators happy and I am sure filled beds make nursing home administrators happy, too. I think we have to sit down and decide which is more important: having every hospital bed filled or providing more cost effective care based on what the community can afford. There are shortages by kinds of skills. The CBS program "Nurse. Where Are You?" made good points about the staggering amount of responsibility the nurse carries, the amount of intelligence required for the job, the amount of knowledge needed, and the kinds of stress nurses work under.

There are places where there are insufficient numbers of nurses prepared to give care in critical care units. It is difficult to get a fix on an absolute numerical shortage, because the number constantly shifts. In addition to the 70% who are working, there are some unfounded suppositions about those nurses who are not working, especially "all those nurses out there who could come back." The 1979 AJN article by Evelyn Moses and Aleda Roth contains a chart about this potential pool of additional nurses. Many of these non-working nurses are age 55 and over. It is only since World War II that nurses have joined the mainstream of the population in participating in retirement plans. Before that, they worked until they were 97 years old. When I was a student, there were private duty nurses working who could barely move. They had no retirement plans and nursing was their only means of subsistence. But once nursing and hospitals could avail themselves of social security and other retirement plans, the nurses participating in the plans could actually retire.

If they were good managers of their money and a bit penurious, they could even retire at 55. Those who can, ought to. Bedside nursing is physically demanding; and the over-55 group is not a group we are going to bring back to nursing. Even so, many nurses are proud of their licenses and continue to keep them in force. Thus they are counted among the available but non-working nurses, but they should not be since it is unlikely that they represent a viable pool to bring back to the bedside.

About 4% of the nation's nurses work in related occupations. The nurses who have dropped out to rear their children represent what I call "a revolving door" group. The size of this group will probably always remain fairly constant because some are dropping out at the same time that others are coming back to work. Fewer are dropping out altogether; more are staying at least part-time. This group is neither lost to the work arena, nor is it a large untapped source for deriving an increase in the nursing supply. In the late 1960's and early 1970's there was a nationwide effort to get non-working licensed nurses back into nursing employment. Over forty states had a year's federal money for staff in this nationwide effort. When the year was over, the consensus was that this was not an efficient use of available funds. Some hospitals have programs for updating skills for nurses who want to return to nursing, but a major national effort would probably be counterproductive in terms of best results for the money spent. People like to talk about all the thousands of nurses out there wanting to come back and needing retraining opportunities. I think that is a myth.

New data from the 1980 sample survey should be out by December. I alert you to watch for it. The sample's up-to-date information will give us the opportunity to project on the national level, and the survey's methodology is considered to be accurate. We will have new data about preparation, numbers, where nurses are, the amount of time they are working, and a variety of other important pieces of information. You, as nurse leaders, need to have that information. I tend to carry aound a reprint of the Moses and Roth article from the AJN, because it is handy information to have to quote to the people espousing these broad generalizations. I will not say there is an absolute shortage of nurses because we do not have any supporting data. There was a time when California's Bay Area had a surplus of nurses because they would not leave the geographical area. There was a time when Denver, Colorado had a surplus of nurses for the same reason, but at the same time Hugo, Colorado, and Trinidad, Colorado were critically short. State levels in terms of nurse-to-population ratios can be deceptive just as the national nurse-to-population ratio can be. I think the new data will be helpful.

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LEGISLATORS' OPINIONS ABOUT NURSING: INTERVIEWS WITH WISCONSIN MEMBERS OF THE SENATE HUMAN SERVICES AND ASSEMBLY HEALTH AND SOCIAL SERVICES COMMITTEE 1980

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Legislators' Opinions about Nursing:

Interviews with Wisconsin Members of the Senate Human Services and Assembly Health and Social Services Committee 1980

by Rebecca S. Lake, R.N., B.S.N.,M.S.

Accountability for Political Action

Nursing recognizes that legislation impacts on nursing practice. Currently, the effects are mostly indirect; however, as State governmental responsibility and control increases, the effects are likely to be felt more directly.

If nursing is to play an active part in the health care system, then politically active nurses are necessary. But political activity without factual foundation is not effective. Nurses also need to know the biases of the legislators to be able to establish a politically sound and feasible plan for influencing health care legislation. To accomplish this, nurses not only need to know legislators' opinions about nursing, but also need to learn methods of political communication that legislators use in preparing health legislation.

Relevant information needs to reach the individuals influencing health care decision-making. By knowing the legislators' routes of communication, nurses can organize their views on health legislation, temper it with their knowledge of legislators' biases, and then more effectively communicate their views through the identified routes. This pilot investigative survey accomplished two important pri-

mary tasks: (1) it described legislators' opinions about nursing; and (2) it identified the methods legislators used to obtain nursing's viewpoints on proposed health legislation. In addition, a third task was included which was to seek legislators' advice concerning how they believe nursing might improve its impact on health care legislation.

Methodology

Design. The purpose of the investigation was to ascertain and describe legislators' opinions about nursing. Therefore a descriptive/exploratory survey approach was used. Data were collected from informants within a limited time frame and were recorded and analyzed. This study was not aimed at discovering the basis for legislators' opinions but rather was intended to identify significant or outstanding impressions they reported.

Political survey research literature suggests that the personal interview is the most productive method to obtain information from political figures. Hence, this investigation utilized personal interviews to obtain opinions about nursing from the 1980 Wisconsin State legislators.

Reliability. The interview questionnaire contained two potential sources of inaccuracy: one being the errors or deficiencies within the instrument itself; and the other, the inconsistencies among individuals responding to, and those analyzing responses to the instrument.

To overcome some of these sources of error, consultation was obtained in development of the questionnaire from experts in the field of survey interview technique from the Survey Research Laboratory at the University of Wisconsin-Madison. To obtain the most accurate assessment of the respondents' answers to the interview questions, three coders listened to and coded each interview tape. Inconsistencies among the coders were minimized by

giving them advance training in objective standardized methods of coding. On coding the six interview questions, only the sixth question received variance in coding. This was due to one coder detecting an additional answer to the question on tape. This answer was subsequently included in the table of interview answers. Therefore, there was a 94% agreement among coders.

Validity. To enhance validity of the questions, a pre-test was done to spot any difficulties that might arise during the interviewing procedure in relation to either the questions or the interview. Four pre-test respondents, knowledgeable about the legislative process and the health care profession, were chosen. No difficulties arose during the pre-test. However, generalizability of the findings of this study are limited, since political climates change rapidly and each State's laws differ in regard to nurses and the professions.

Sample size. The study included interviews with all members (N=19) of two selected committees of the Wisconsin State Legislature: The Assembly Health and Social Services Committee, and the Senate Human Services Committee. These two standing committees were chosen because they represented both the Senate and the Assembly, and because they were involved with the majority of health-related legislation potentially affecting nursing or groups of nurses in Wisconsin.

The staff of the Legislative Reference Bureau provided assistance in selecting and contacting the members of these legislative committees.

Characteristics of the Respondents. Of the nineteen potential respondents available for the study, five were current members of the Senate Human Services Committee and fourteen current members of the Assembly Health and Social Services Committee. (Table 1 contains additional personal data about the potential respondents.) The majority of the respondents were 30-39 years old, Democrats, from rural areas of the State of Wisconsin, and had been

members of their respective committees for less than four years.

Eighteen of the nineteen actually participated in the interviews. One Senator was not interviewed because a convenient interview appointment could not be negotiated.

Procedure

Interviews were arranged with 18 subjects and a letter of introduction, intent, and request for personal interview was sent. The interview questions were included with the initial contact letter. A follow-up telephone call to each legislator's capital office secured an interview appointment.

After the interview appointment was made, a confirmation letter was sent to each participating legislator indicating a 15-minute time limit for the interview. With each legislator's permission, the interviews were taped. Each potential respondent had the opportunity to refuse to be interviewed or to answer any question during the interview. Respondents' tapes were identified by an arbitrarily assigned number. Only the code number was used by the researcher in reference to any tape, and the tapes were destroyed once the data had been analyzed.

Results and Discussion

Respondents' ages, political party affiliation, geographic legislative areas, and years as members of their respective committees demographic data are shown in Table 1. Responses from the 18 interviews are presented in Tables 2-7. Percentages are based on the number of actual respondents (N=18).

The questions presented to individual legislators, and a summary discussion of their responses are as follows:

Question 1: How does nursing fit into the delivery of health care to citizens of Wisconsin?

TABLE 1

DEMOGRAPHIC DATA: WISCONSIN LEGISLATORS PARTICIPATING IN SURVEY (N=18)

	Sen.	Assem.	Total
Age			
30-39	3	9	12
40-49	0	2	2
50-59	0	3	3
60-69	1	0	1
Sex			
Female	1	2	3
Male	3	12	15
Marital Status			
Single	3	2	5
Married	1	10	11
Widowed	0	2	2
Education			
Attended College	0	1	1
College Degree	3	8	11
Higher Degree (graduate degree & higher)	1	5	6
Occupational Preparation			
Attorney	1	3	4
Teacher	1	2	3
Business	1	2	3
Legislative Assistant	1	4	5
Medical	0	2	2
Other	0	2	2
Legislative Area			
Urban	1	4	5
Rural	3	10	13
Party			
Democrat	3	9	12
Republican	1	5	6
No. Years on Committee			
1-2	3	7	10
2-4	0	4	4
4-6	1	1	2
6-8	0	1	1
8 and up	0	1	1

The majority of respondents, 73% (N=13), believed nursing has a vital role, and plays a large and integral part in the delivery of health care. Eleven percent of respondents, (N=2), believed nurses were employed in health care to aid the doctors. One legislator thought nursing functioned only in a hospital setting, while another saw nursing in a primarily supportive role. One legislator did not know how nursing fit into the delivery of health care to Wisconsin citizens.

Of the 12 legislators 39 years and younger, 9 (75%) believed nursing played a large and varied role in health care delivery to citizens of Wisconsin, whereas only 3 (50%) of the 6 legislators 40 years and above concurred. Ten of the 12 Democratic legislators, (83%), viewed nursing has having a large role in the health care delivery system as compared to 3 of the 6 (50%) Republican legislators; 28% of all subjects saw nursing in a more narrow, passive role in the delivery of health care. Residence of legislators did not appear to influence their opinion about nursing as the majority of both urban and rural legislators, (70%), believed nursing played a large role in the delivery of health care. All of the 4 respondents who had served on the two committees five years or more thought nursing had a large and varied role in the delivery of health care, as compared to the legislators serving on the committees four years and under, 65% (N=9).

CATEGORIZED RESPONSES OF PARTICIPATING LEGISLATORS TO THE SIX SURVEY QUESTIONS

TABLE 2

Question 1: How does nursing fit into the delivery of health care to the citizens of Wisconsin?

Roles	Total (N=18)	% of Responses
Vital Role Integral part Variety of roles	13	72
Hospital based	1	6
Supportive role	1	6
Aid to Doctors	2	11
Did not know	1	6
Total	18	100%

Question 2: Name bills before your committee which you think might influence or involve nursing or groups of nurses.

Ten legislators (56%) identified two bills before their committees which might influence nursing or groups of nurses. These two bills contained the word nurse in their titles: "Nurse Midwifery Bill," and "The Statewide Study on Nursing." Six legislators cited additional health-related bills which might influence nursing. A listing of some of the health-related bills, which might influence or involve nursing before these two committees, was included in the study for reference. Two respondents did not identify any bills before their committees that might influence nursing. Thus, the majority of the legislators thought nursing was influenced only by bills which contained the word nurse in the title.

Eight of the "under-40" legislators (67%) cited two bills which contained the word nurse in their titles as influencing nursing, while 3 (50%) of the "over-40" legislators identified additional health-related bills which might influence nursing.

TABLE 3

Question 2: Name bills before your committee which you think might influence or involve nursing or groups of nurses.

Bills	Total (N=18)	% of Responses
Nurse Midwife Statewide Study on Nursing	10	56
Other health-related bills in addition to two mentioned above	6	33
Can't remember	2	11
Total	18	100%

More Republican legislators, 67% (N=4), identified other health-related bills which might influence or involve nursing than did Democratic legislators, 16% (N=2). More urban (80%) than rural (46%) cited only the two bills which contained the word nurse in

their titles as influencing nursing, viewing nursing in a narrower perspective. Of the legislators with 4 years or less experience on these committees, 64% (N=9) cited only the two bills which contained nurse in their titles as bills which might influence nursing as compared to 25% (N=1) of the legislators on the two committees five years or more. However, half, 50% (N=2), of the legislators on the two committees five years or more did not answer the question. Although equivocal, it appears from Tables 1 and 2 that length of time on the legislative committee improves legislators' realistic understanding of the role of nursing in health care.

Question 3: Where do you get information on nursing's reaction to proposed health care legislation?

All respondents reported that their primary source of information about nursing's viewpoint on proposed health care legislation was letters written by nurses. Form letters, however, were described as 'unacceptable', 'never read', or discarded by a substantial portion, 61% (N=1), of the legislators. Two additional methods of communication mentioned by the legislators included testimony presented by nurses at public legislative hearings, 66% (N=12), and telephone conversations, 55% (N=10). Written testimony was the least appreciated method of communication from nursing to the legislators, who described this type of communication as consisting of many pages of opinions but offering a limited amount of valid information.

The Wisconsin Nurses' Association (WNA) lobbyist and meetings with constituency nursing groups, including personal friends and relatives who are nurses, were mentioned as additional sources. One respondent received information concerning nursing's views on proposed health legislation from a relative who was a ward manager (clerk) in a hospital.

TABLE 4

*Question 3: Where do you get information on nursing's reaction to proposed health care legislation?**

Methods	Total N=18)	% of Answering **
Telephone	10	56
Letters	18	100
Public Hearings	12	67
Meetings with Nurses	6	33
Lobbyist	7	39
Personal friends, and/or relative a nurse or part of health care team	7	39
Written testimony	2	11
Total	44	

*Form letter unacceptable: 61%
Form letter acceptable: 39%

**Percent totals more than 100 because respondents could cite more than one method.

Half of the respondents under 40 and half over 40 used public legislative hearings and telephone conversations to obtain nursing's views on health legislation. The WNA lobbyist was used as an information source by five (18%) of the "under-40" legislators: and two (12%) of the "40 and over" respondents. Nursing friends or relatives, and others in the health care field (excluding physicians) were used as information sources by 3 (19%) of legislators 40 and over as compared to 4 (15%) of those under 40.

Next to letters, public legislative hearings and telephone conversations are the main methods of communication used by committee members of any age. Public legislative hearings and telephone conversations also comprise from 49% to 54% of effective communication to both Republicans and Democrats. Of the Democrats, 17% (N=5) employed the WNA lobbyist as a communication source, with slightly more than that reported by the Republican legislators' 13% (N=2). Twenty percent (N=3) of the Republican legislators utilized nursing friends and relatives, and others in the health care field (excluding physicians), compared to 14% (N=4) of the Democratic legislators.

Urban/rural differences showed that 45% (N=4) of urban legislators used public legislative hearings as the major method of obtaining nursing's reaction to proposed health legislation, and 23 (69%) of rural legislators used public legislative hearings, telephone conversations and the WNA lobbyist to obtain nursing's views on legislation. No urban legislator reported using the WNA lobbyist as a source of information concerning nursing's views on health legislation. For legislators who had served on these two committees five years and over, 37% (N=4) used public legislative hearings for gaining nursing information, compared to 25% (N=8) of legislators serving 4 years or less. One legislator with over five years of committee service cited telephone conversations as an information source concerning nursing's views on health legislation as compared to 9 (27%) with committee terms of four years of less.

Of the remaining methods identified for obtaining nursing's views on proposed health care legislation, the legislators employed them approximately equally.

Question 4: What do you see as the impact nursing has on health care legislation?

All but one of the respondents thought that nursing has no impact, or minimal impact on health care legislation. One legislator stated that the impact of nursing on health legislation was good.

The 6 legislators 40 years and over described nursing as having no impact or little impact on health care legislation. And all but one of the "under 40" legislators agreed. All Democratic legislators (N=12) believed nursing had none or only some impact on health legislation. And 5 of the 6 Republicans concurred. Thus, 15 of the 18 legislators--regardless of age, political party, legislative area or number of years on these two committees--believe nursing has no impact or little impact on health legislation.

TABLE 5

Question 4: What do you see as the impact nursing has on health care legislation?

Impact	Total (N=18)	% of Responses
None/Limited	12	67
Some/Fair	5	28
Favorable/Good	1	5
Total	18	100%

Question 5: How do you rate nursing's impact on health care legislation as compared to other health related organizations?

Over three-fourths, 78% (N=14), of the respondents rated nursing's impact low on health legislation when compared to other health-related organizations. Two respondents rated nursing as "fair" and two others rated nursing as "good".

Of younger respondents, 92% (N=11) rated nursing "low " or "fair." Respondents 40 years rated nursing either "low," 83% (N=5), or "good," 17% (N=1). Democratic respondents, 92% (N=11), rated nursing "low" or "fair," while Republican respondents, 84% (N=5), rated nursing "low" or "fair." All urban legislators (N=5) rated nursing "low," while 70% (N=9) of the rural respondents rated nursing "low." All Members of the two committees who served five years and over (N=4) rated nursing "low." Of the respondents who

served on these two committees four years or less, 72% (N=0) rated nursing "low." As the figures indicate, 89% of all legislators rated nursing "low" to "fair" in its impact on health care legislation compared with the impact achieved by other health-related organizations.

TABLE 6

Question 5: How do you rate nursing's impact on health care legislation as compared to other health related organizations?

Rating	Total (N=18)	% of Responses
Poor/low	14	78
Some/Fair	2	11
Good	2	11
Total	18	100%

Question 6: What advice would you give nursing to improve its input into the legislative process?

The majority of the responses, 83% (N=15) indicated that nurses need to educate the legislators on the profession's views, its specific insights into the health care field, and health legislation. Also, 67% (N=12) indicated that nursing should be more organized and present a unified front on political issues; 61% (N=11) suggested that nursing increase its involvement in grassroots constituency work in their legislators' districts. In addition, 44% (N=8) said that nursing needs to present a broader perspective in its response to health care legislation instead of being "single-issue focused," e.g., licensure fee increases and/or bills specific to nursing. Other ways suggested to improve nursing's impact on health legislation were: (1) increase the utilization of a nursing lobbyist; (2) obtain news media support; (3) use political contacts such as friends, neighbors, or professional acquaintances who are members of the legislature; (4) prepare one-page reports

on specific bills of interest to nursing so that legislators have written documentation and evidence of support from the nursing profession.

TABLE 7

Question 6: What advice would you give nursing to improve its input into the legislative process?

Advice	Total (N=18)	% of Answering*
Get organized	12	67
Broader Perspective	8	44
Involvement in Grass Roots Constituency action	11	61
Educate Legislators	15	83
Total	46	

*Percent totals more than 100 because respondents could advise more than one means.

Legislators 39 years and younger, and those 40 years and over agreed on the advice given to improve nursing's impact on health legislation: organize, educate legislators, increase grassroots work. More Democratic legislators, 32% (N=10), indicated that effective organization of the nursing profession was the key for better impact on health legislation than did the Republican legislators, 14% (N=2). More urban legislators, 34% (N=4), indicated that nursing should be organized to improve its legislative impact than did the rural legislators, 24% (N=8). Responses from members with committee service five years and above, 17% (N=3), indicated the need for nursing to be less "single-issue focused" and to assume a broader health care perspective that would improve nursing's impact on health legislation, as compared to 14% (N=5) from members with committee service four years and under. As for education, both Republican legislators' responses, 43% (N=6), and Democratic responses, 28% (N=9), suggested that education of the legislators was a way for nursing to improve its im-

pact on health legislation. More rural legislators, 35% (N=12), indicated the need to educate legislators as a means for improving nursing's legislative influence, than did urban legislators, 25% (N=3). Of the respondents on the two committees having served five years and over, only 19% (N=2) specified education of legislators as compared to 37% (N=13) of the committees four years or less, as a way for nursing to improve its legislative impact.

Members of the two committees who served five years and over viewed three methods as having equal importance to the improvement of nursing's impact on health legislation: (1) organization of the nursing profession; (2) greater grassroots constituency involvement; and (3) formation of a broader perspective in regard to health care legislation. Having served a longer period they may have believed they needed less education about nursing issues.

Conclusions and Suggestions

The majority of the legislators 30-39 years of age, Democrats from urban areas, and members of these two committees over five years, tended to see nursing in a large and varied role in Wisconsin's health care delivery system. Legislators over 40, Republican, from rural areas, and on the committee under four years, revealed a narrower perspective concerning the role of nursing in health care delivery. Awareness of these legislators' perspectives concerning nursing's role in health care may help nursing plan more effective strategies. Nursing may emphasize the broader role of the nurse by defining and outlining these roles for the legislators, and perhaps involve the news media in publicizing the work being done. The recognition of these numerous and well-defined nursing roles may lead the legislators to acknowledge that nursing has an interest in and a position on many issues surrounding health care delivery and health legislation.

Nursing can plan a strategy of information dispersal to counteract legislators' inaccurate assumptions about nursing. To ensure the strategy's success, the nursing profession should do the following:

(1) increase its presence and participation at legislative public hearings; (2) submit brief written testimony at the hearings and to each of the legislators on the appropriate committees; (3) send to all legislators a monthly or quarterly newsletter (prepared by the WNA lobbyist) informing them of issues concerning nursing and the profession's stand; and (4) send to each legislator a list of nurses in their constituency area, which would include the nurses' areas of expertise, their addresses and telephone numbers. In addition, nurses can routinely focus news media coverage on the profession's views of health issues being considered by legislative committees, and on nursing's suggestions to assist with proposals of new health care legislation. Media coverage will help to inform legislators of multiple health care interest areas where the nursing profession either exercises influence or is directly involved. By enlarging the legislators' perspective of nursing, nurses could enable legislators to strengthen their opinions about nursing as a profession and to be contacted for information on health care matters.

Nursing's Impact on Health-Care Legislation

All legislators reported using letters sent by nurses as a method of obtaining information. Also, legislators utilize telephone conversations and public hearings to learn nursing's opinions on proposed health legislation. It is essential for nursing to know and use these channels. Utilization of these routes would assist the profession to improve its legislative impact.

Over two-thirds of the legislators (the majority, Democrats from urban areas) rated nursing's impact on proposed health care legislation as "none" or "limited." This information can be useful in two ways: (1) it can serve as baseline data to evaluate the methods used by nursing to change the opinions of legislators about nursing's impact; (2) the information allows the identification of groups of legislators to which nursing can direct it efforts to change this rating. Also, a longitudinal data survey by nursing is now possible to record changes in the legislators' opinions about nursing.

The majority of the legislators suggested nursing become organized to increase its impact, because dissention within the nursing profession was seen as reducing credibility of views on nursing and health care. In addition, the legislators stressed the need to have nursing's involvement in grassroots constituency action. Nursing's involvement in the campaign work of legislators in their particular legislative districts is beneficial, since grassroots work simultaneously builds a legislative constituency which, in turn, has an influential power base. Also, legislators are more likely to take into consideration the views of nurses residing and voting within their legislative districts.

The primary advice from the majority of Democrat urban legislators to nursing was to organize effectively; whereas, all Republicans and nearly all rural legislators said that the education of the legislators was most important. Wisconsin nurses have thus acquired direct, valuable information from these legislators which may help them to improve the profession's impact on proposed health care legislation.

Implications

The results of this survey identify the need for nursing to sharpen its political image for greater impact on health care legislation. Since the profession is affected by health care legislation, political action is vital if nursing is to be in control of its own future. From this study we have seen that it is a fallacy to assume that legislators know and understand the multiplicity of nursing roles, and functions, and responsibilities. The education of legislators about nursing is a task for organized nursing in every State.

This pilot survey indicates nurses are politically inactive. One way to encourage and shape political activity among nurses would be to incorporate classes or content on the legislative and political process into professional nursing educational programs. It could be accomplished by instituting practical and/or experiential courses in which students attend legislative hearings, prepare testimony and follow a specific piece of proposed legislation from introduction to adoption or defeat within a given legislative session. Effective political skills will become increasingly essential for future nursing leaders.

OVERVIEW OF METHODS FOR ACHIEVING SUCCESSFUL POLITICAL OUTCOMES, WITH EXAMPLES OF STRATEGIES FOR NURSES

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Overview of Methods for Achieving Successful Political Outcomes, with examples of Strategies for Nurses

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Madison, WI

In 1875, Alexander Graham Bell said, "I suppose it will not be long before we have a woman wanting to be President. If women want anything, they are sure to get it in the long run--so we had better give in gracefully, at once." Unfortunately, Mr. Bell's expression "at once" was definitely not equivalent to "stat," since over one hundred years have passed since he uttered this prophecy.

Today, nurses want to effect certain political outcomes before the passage of another hundred years. But how does nursing go about successfully accomplishing its goals? Briefly outlined are some strategies that nurses may use to influence political decision-making. (As a side note the Wisconsin organizations mentioned here have counterparts in other MAIN states. While some of the meetings mentioned may already have taken place, these examples illustrate the activity nursing groups are sponsoring to heighten political awareness. This conference of MAIN's is an example).

POLITICAL CONSCIOUSNESS-RAISING CONFERENCE/WORKSHOPS/EDUCATIONAL PROGRAMS

1) N-CAP (Nurses' Coalition for Action in Politics), the political arm of the ANA, sponsored a political action workshop in Washington, D.C., September 1981.
2) State nurses association conventions usually discuss political activities, e.g., at WNA convention held in October the Legislative Commission planned two politi-

cal presentations. One featured Alan Kasprzak, legislative liaison for the Wisconsin Department of Health and Social Services, and Larry Patton, Senator William Proxmire's health aide, who discussed the impact of the federal budget cuts on health services at the state level. At the second presentation, a panel of three state legislators discussed state legislative issues involving nursing.

3) Nurses' presentations via an educational telephone network of continuing education in nursing regarding the legislative process. (Rebecca Lake is a prime example and will give a presentation in January 1982 for Wisconsin.

4) The upcoming ANA Convention on June 25-July 1, 1982, in Washington, D.C. will address political activities.

5) A legislative workshop sponsored by WNA is planned for January, 1983. The last workshop dealt with the following areas:
   a) Overview of the legislative process.
   b) Reading a bill; learning the difference between statutes and regulations.
   c) Everything you always wanted to know about hearings.
   d) Communicating with your legislator.
   e) Presentations of a nursing related bill.
   f) Preparing testimony for hearings and letters for communicating with legislators.
   g) Presentation of testimony at mock hearings.

6) Politics/Economics/Health

   a) Legislation at the state and local levels
   b) Rate review
   c) Funding
   d) Nursing and Medicine issues

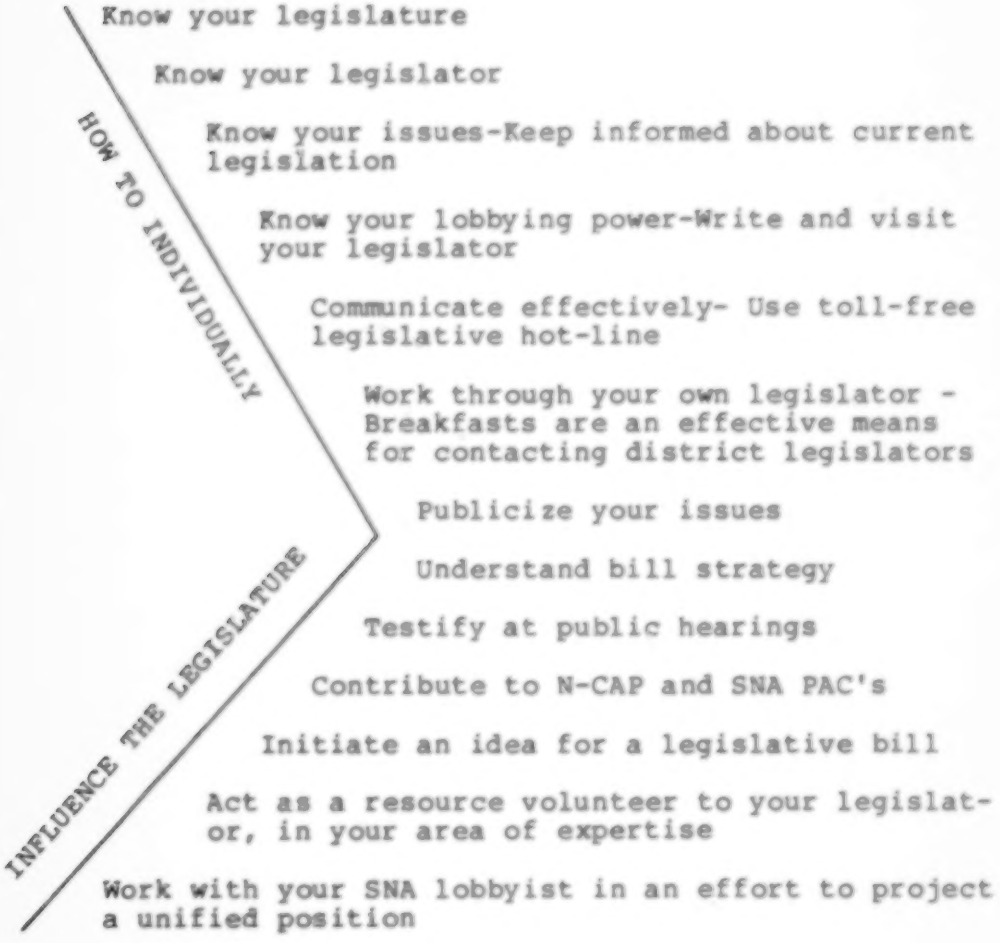
7) White House Fellowships

   a) Nurse applicants should contact their state nurses' association.

RESOURCES AND REFERENCES

1) Wisconsin Legislative Directory--Wisconsin Manufacturers' Association.
2) Legislative Bulletin--WNA.
3) Legislative Outlook--WNA.
4) Directory of the 1977 Wisconsin Legislative and Congressional Districts--Wisconsin Taxpayers' Alliance.
5) National Health Directory--Science and Health Publications, Inc.
6) More articles in MAINlines (like the Summer 1981 article entitled "Nursing's Role in Health Policy-Making" by Carolyn Littlejohn)
7) Know Your State Wisconsin--published by the League of Women Voters of Wisconsin.
8) When You Write to Washington, A Guide for Citizens Action--League of Women Voters Education Fund.

HOW TO INDIVIDUALLY INFLUENCE THE LEGISLATURE


HOW TO INDIVIDUALLY INFLUENCE THE LEGISLATURE
Know your legislature
Know your legislator
Know your issues-Keep informed about current legislation
Know your lobbying power-Write and visit your legislator
Communicate effectively- Use toll-free legislative hot-line
Work through your own legislator - Breakfasts are an effective means for contacting district legislators
Publicize your issues
Understand bill strategy
Testify at public hearings
Contribute to N-CAP and SNA PAC's
Initiate an idea for a legislative bill
Act as a resource volunteer to your legislator, in your area of expertise
Work with your SNA lobbyist in an effort to project a unified position

HOW TO INDIVDUALLY BECOME ACTIVE IN POLITICS

Candidate Campaign Components

Advance People	volunteer drivers for the candidate or press, gather local political information, i.e., who should sit on the platform with the candidate
Field Organization	literature drops, door-to-door canvassing, telephone canvassing, get-out-the-vote rallies, provide transportation for voters
Finances	fund raising, financial bookkeeping
Media	literature, radio, TV, buttons, billboards, bumper stickers
Office Work	staff campaign headquarters, coordinate mass mailings, recruit volunteers
Polling	telephone to poll question
Press	clerical assistance
Speeches	research papers, speech writing, expert advisor on health issues

Party Work

Run	for local/state/national party office
Work	at local/state/national party level

Convention Delegate at National Level

Gain	exposure
Make	political contacts
Use	as stepping stone for future political role

Involvement in Good Government Group

- Common Cause
- League for Women Voters
- Wisconsin Women's Political Caucus
- Young Democrats/Republicans

Elect Nurses

Register and Vote

Run for Office Ourselves

Write Letters to the Editor

Form Alliances with Others

Project a Unified Position to the Public

Seek Membership on Boards and Committees Which Have Policy and Decision-Making Power

POLITICAL ACTION COMMITTEES

State Level: WINPAC Wisconsin Organized in 1976. More than 30 States Have PAC's

Fundraising	celebrity Auction, 1980 WNA Clinical Sessions
Screening	committee which interviews incumbent politicians and challengers regarding their stands on nursing issues
Endorsing	candidate
Contributing	to candidates, e.g., Walter Kunicki, a nurse elected to the 1981 Wisconsin Assembly (money, consultation, campaign organizing, office support)
Organizing	get-out-the-vote drives
Coordinating	non-partisan registration

Federal Level: N-CAP

Non-Profit Non-Partisan	political action arm of ANA which was organized in 1974 differs from ANA govenment relations office which lobbies on behalf of ANA
Priority	to qualified women candidates
Receive	recommendations from state nursing association, and state PAC's, individuals, other nursing organizations

Federal Level: N-CAP (continued)

Functions	N-CAP encourages political education and involvement; raises funds and makes contributions ($99,000 in 1980 as compared to $1,700,000 by AMA); learns political record of office holders and candidates; and knows political issues
Selected Publications	The Political Nurse, bi-monthly publication A How-To-Do-It Fundraising Book Getting Involved in Politics: A How-to-do-it Guide Know your Congresspeople: A How-to-do-it book on researching their public record Register to Vote and Voting Leaflet Congressional District (CD) Manual: Time for Nurses to Make a Difference Through Politics
CD Coordinators	N-CAP is looking for CD coordinators, a nurse in each congressional district who will work on behalf of the candidate who is most supportive of nursing positions

NURSING POLITICAL NETWORKS

A. See, Virginia Nurses' Association/American Journal of Nursing Excellence in Writing Award 1980 article--"A Prescription for Political Activation: Nursing Political Networks" by Sandra Shirley Messer, R.N.

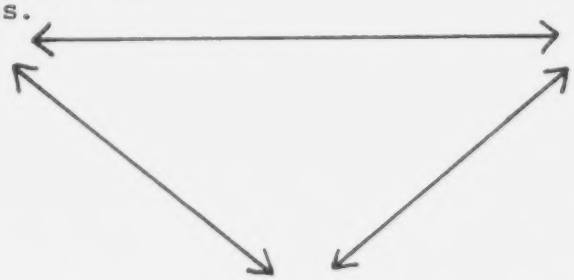
B. Need for nursing research on cost effectiveness.

C. Expansion of nursing curricula and continuing education courses to include courses on health care issues and government policy-making.

D. Need for accelerated development of three kinds of political nursing networks:

Analogy to "Old Boys" network in which nurses with experience in political lobbying and policy formulation would make referrals and systematically help younger or less experienced nurses who also have political aspirations.

Vehicle for putting nurses with practical expertise directly in touch with legislators and regulators.



Series of long distance or regional telephone trees used when rapid, mass mobilization is required.

Wisconsin has both a state and federal nursing legislative network currently in place.

Ms. Michels instructed the meeting attendees to break into four caucus groups to identify specific issues, and then make recommendations for action to bring about the desired outcomes. Groups were also asked to make suggestions for implementation of the recommendations to be accomplished by individuals, by state-level nursing organizations and by the region (MAIN). Attendees were reminded that subsequent to Alexander Graham Bell's prophecy, women have become legislators, lawyers, high government officials, and a U.S. Supreme Court Justice --so why not a woman President, as long as she is a nurse!

After the caucus sessions were completed (the caucus reports appear later in these proceedings), Ms. Michels summarized the reports and answered questions from the audience:

Summary Report of Caucus Discussions

Attendees learned about each other as they planned recommendations for developing networks among themselves. They identified specific issues, made recommendations for action, and suggested ways of implementing the recommendations. In the process, the caucus groups were found to have overlapping interests. Many issues were common to all groups so it was difficult to sift out unique issues from each one. Overlapping among the groups also occurred when making recommendations and strategies. The following is a synopsis of the issues addressed, including recommendations and strategies for implementation.

The top priority issues were:

1) The need to clarify the interrelationship of nursing service, education and research.

2) Whether standards of practice, specifically as they relate to individual nurse practice acts, should be devised, as if so, whether it should be done by state boards of nursing or some other designated group.

3) Whether state nurse practice acts currently include, or should include, language dealing with these area:

   a) Definition of competence.
   b) Expanded roles for nurses.
   c) Mandatory continuing education as a requirement for relicensure.
   d) Sunset laws.
   e) Levels of licensure.
   f) Licensure examination content.
   g) Application for licensure.
   h) Composition of boards of nursing.

4) The need for state boards of nursing.

5) The need for nursing research on cost effectiveness.

6) Nurses need to be knowledgeable about the allocation of federal and state monies for health, especially block grants; who determines which areas of nursing will be funded; health promotion; marketing research; and population needs.

7) Expansion of nursing curricula and continuing education courses to include courses in health care issues, government policy-making and networking.

The recommendations of the caucuses are aimed at three levels: individual, state, and regional (MAIN):

Individual

1) Volunteer for task forces.
2) Serve as nursing consultants to legislators.
3) Testify at hearings
4) Monitor the legislature by maintaining communication with legislators, state nursing association, and/or other effective mechanisms.
5) Keep abreast of educational issues.
6) Get to know the governor and state legislative committees.
7) Keep legislators educated and informed.

8) Talk to consumers to ascertain their priorities on health care and how much money they are willing to spend.
9) Form consortia with different consumer groups.
10) Introduce yourself to community leaders, particularly key people in the decision-making process.
11) Health care groups should form coalitions among themselves, with individuals help.
12) Appear at hearings and other meetings to determine where monies will be spent.
13) Maintain standards of practice.
14) As a nursing school alumna, hold appropriate individuals responsible for running of school; contribute financial support.
15) Communicate frequently with other members of the profession.
16) Initiate legislation favorable to nursing that is proactive rather than reactive.
17) Write legislators.
18) Be assertive: stand up and fight for nursing.
19) Run for political office and win.

State

1) Form networks and coalitions among nursing, but also with health-care groups and consumer groups.
2) Initiate legislation favorable to nursing that is proactive rather than reactive.
3) Monitor proposed legislative changes to the state nurse practice act.
4) Monitor the state board of nursing.
5) Back nurse candidates for political office as well as other pro-nursing candidates.

Regional (MAIN)

1) Become a clearing house for successful and unsuccessful nursing projects.
2) Analyze legal decisions regarding health care and publish these in MAIN's newsletter MAINlines how these decisions will impact on various states.
3) Recommend legislation at the federal level.
4) Sponsor political workshops and teach MAIN members how to sponsor workshops in their respective states.
5) Establish a liaison with the Midwest Governor's Group, National Council of Governments, National Council of Mayors, and other political groups.
6) Gather data on the cost effectiveness, of nursing services, especially in area of illness prevention.

The four caucuses--Practice, Licensure, Education, and Community Health--discussed a wide range of topics in a short length of time. One is reminded of the saying: "There are three kinds of people: those who make things happen; those who watch things happen; and those who wonder what happened." The concrete recommendations made by the caucuses reveal that MAIN people make things happen.

The following dialogue took place with the audience:

In one of the caucus groups, someone said that "Starting Monday, some political activist such as MAIN needs to represent us, and also take the synopsis of the materials and publish them in MAINlines. In this way, everyone who could not be here could be informed, and people could build bridges to the necessary groups within the states to move the information along."

I like that--"Starting Monday"--that is good. The important questions are "Who will be the consulting people?" and "Who will give time to be the volunteers with the legislators?" These questions are difficult for nurses with many other commitments.

One method to find answers to these questions would be to survey the group. Perhaps MAIN could distribute a survey asking who wants to do work and who wants to help.

Such a survey might be included in MAINlines where one could fill out a form listing areas of expertise and areas of volunteer work.

Some people here today are already doing that and they can also represent MAIN.

That's a very good point.

I have a question about some of this. I assume that the recommendations pertinent to MAIN will be sent to MAIN's Governing Board for sorting and prioritizing. My caucus group discussed the possibility of MAIN being a clearinghouse. If we are to report only successes, we might not have such a long list. It is just as important to share unsuccessful outcomes as those which were successful. When the MAIN Governing Board examines these recommendations and decides what to do, they should include the items happening that are important to the other states. It is not just a matter of "go thou and do likewise," but "go thou and do differently." I hope that MAIN's Governing Board will consider these things when they receive the list of recommendations.

That point is well taken because people learn by mistakes as well as by successes.

There are a number of things suggested for MAIN to do. I am certain that the Board will be glad to look these over and make recommendations as to priority, but all of these items are services. All services require personnel which in turn require money. The membership committee gave us a report yesterday during the Board meeting and we talked about ways to increase the number of member agencies.

This might be an appropriate time to urge those of you here to return to your states and encourage people who are not members to become members of MAIN. In this

way, MAIN could probably provide the services that we would like to have provided, but in order to do this, we have to have money and money comes from membership.

Listening to the recommendations for MAIN, it seems to me that if we are wanting to report through MAINlines or other publications, we are suggesting a formal network. These are things, that happen within states that need not be publicized. Nursing colleagues need to know how to avoid adverse publicity, but we can discuss informal events at meetings like this.

I'll use an example of something that happened two years ago. In apparent innocence, the Ohio Nurses' Association attempted to update the definition of the practice of nursing in the state. This was interpreted by other groups as being a way to get the entry-into-practice issue settled. Many state legislators still recall when busloads of LPN's arrived in the Rotunda not knowing why they were there, but it was to be against something. Some of us are still hearing about this: how one group of nurses will use another group. I think that we need to share with each other, but perhaps not always through publication. There may be a time, in committee meetings, to close the door and lay it all our among friends what it is we want to warn one another about.

This is also a point well taken.

From the course the conference has taken today, one of the things most beneficial to me and other people I have talked to is the time allotted for sharing ideas within sessions. I am certain a number of us could have become hot and heated during the thorough discussion of issues in the caucus groups, and maybe even in a large group like this. Most of the information communicated was excellent. It is reassuring to see the speakers and other people here agreeing.

This is the first time that we have had a chance to be represented among you since we at Michigan State University School of Nursing survived. That survival was accomplished in part because of the activities of our staff and faculty, and in part due to many of you. We are very appreciative of that.

CAUCUS SESSIONS

PRACTICE ISSUES

Leader: Linda M. Kielas, RN, BSN
Director
Department of Nursing
Illinois Hospital Association
Oak Brook, Illinois

EDUCATIONAL ISSUES

Leader: Helen K. Grace, BSN, MSN, PhD, FAAN
Dean and Professor
College of Nursing
University of Illinois at the Medical Center
Chicago, Illinois

COMMUNITY HEALTH ISSUES

Leader: Carolyn E. Littlejohn, RN, BSN, MSN
Director of Education
Visiting Nurses' Association
Milwaukee, Wisconsin

LICENSURE ISSUES

Leader: Shirley A. Ross, BSN, MPH
Associate Professor
School of Nursing
Indiana University

Member, Indiana State Board of Nurses'
Registration and Nursing Education
Indianapolis, Indiana

CAUCUS SESSIONS

The purpose of the Caucus sessions was to identify the truly important legislative issues that need nursing intervention, support, or resistance. There was time for discussion of only two or three major issues in each group. Therefore, groups attempted to focus on two or three issues to develop strategies for dealing with them, rather than discussing many topics superficially.

To ensure comparability of caucus recommendations a Caucus Summary Form was used by Caucus leaders to summarize and report each group's recommendations. Expected outcomes of the Caucuses were:

* discovery of commonalities among issues identified in two or more states
* development of a collaborative approach to strategizing for political action
* suggestions for establishing a permanent regional political strategy network for nursing
* keeping a current list of key legislators in MAIN's states, along with knowledge of their voting records in relation to nursing issues

CAUCUS GROUP I: NURSING PRACTICE ISSUES

Leader: Linda M. Kielas, RN, BSN

The most important legislative issues were:

a. Legislation which affects the supply/demand equation: Nurse Training Act Funding, funding of nursing education at state level via grants, scholarships and loans.

b. Revisions needed in Nurse Practice Acts to accommodate expanded nursing practice.

c. Reimbursement for nursing from third party payors.

NURSING PRACTICE ISSUES

RECOMMENDATIONS/STRATEGIES

For Individual Nurses:

(1) Become more aware/better informed on issues which affect nursing practice via reading, continued or continuing education, and participation in well informed groups.

(2) Assuming #1, respond to community group's need for programs and information appropriate to nursing input.

For State-level Nursing Organizations:

(1) Develop collaborative relationships with state level groups who represent not only health related constituencies, but consumer, civic, political, and governmental memberships.

(2) Develop a single resource pool for accurate documented information on current issues at the state level.

(3) Develop educational programs to increase understanding and skill levels of individual nurses to effect legislative change.

For MAIN:

(1) Develop a central information resource center for issues being addressed throughout the region. Provide a generic analysis of the long term effect of these issues on the remainder of the region.

(2) Upon recommendation of central resource center (#1), define those issues which need the support of research and seek appropriate experts to accomplish specific research goals.

(3) Provide educational programming to update the membership on activities of both #1 and 2.

CAUCUS GROUP II: EDUCATION ISSUES

Leader: Helen K. Grace, BSN, MSN, PhD, FAAN

Issues discussed were:

(1) Creative approaches to alternate funding; creative approaches to keep up quality even with limited funding.
(2) Articulation between education and practice.
(3) Insufficient research-base for issues affecting nursing.
(4) Flexible approaches to education.
(5) Qualified individuals to teach.
(6) Continuation of clinical competence for educators.
(7) Support-system for faculty research.
(8) Continuing credibility.
(9) Legislative sanction for expanded role of nurses.
(10) Diploma programs, becoming a single-purpose unit conferring baccalaureate degree.
(11) Institutional attitudes toward private practice of faculty.
(12) Lack of unity between nurse educators.
(13) Joint appointments for service and education; lack of unity and direction toward common goals.
(14) Increasing cultural diversity-minority needs.

Issues given top priority were:

(1) Interrelationship of Service/Education/Research.
(2) Clarification of educational pathways toward first professional degree and entry into graduate programs.

RECOMMENDATIONS/STRATEGIES

For individual and State level organizations:

(1) Education, Service and Research:

a. shared appointments, e.g.
- nursing service representatives in curriculum committees.

RECOMMENDATIONS/STRATEGIES

- faculty representatives on patient care committees

b. development of lasting, mutually beneficial collaborative systems.

c. determine purposes for which educators, practicing nurses, and researchers will want to get together; then operationalize a system for it.

d. need not only to respond to, but also initiate legislation.

Use research data as the basis for introducing legislation.

Determine the mechanisms for utilizing the legislative process as a point of coalition; e.g. regional service and education groups; participation in pre-hearing briefings, service and education should get together before testifying; Example: Grant for utilization of nursing homes for teaching. There is little apparent articulation-collaboration among various agencies.

e. other suggestions for coalition of education, service, and research.

1. Activities should be organized around a local theme.
2. Nurses should concern themselves with consumer advocacy; nurses need to expand their consumer consciousness.
3. State networking; know local and state agencies, write speeches for legislators
4. Develop appreciation for one another's contributions and role, e.g., midwives and psychiatric nurses.

f. suggested economic, political, and fiscal action.

1. "Obey the law day" to illustrate need for change.
2. Help develop and use data base on cost effectiveness and benefits of nurses.

CAUCUS GROUP III: COMMUNITY HEALTH

Leader: Carolyn E. Littlejohn, RN, BSN, MSN

Most important legislative issues discussed:

(1) Money-competition for funds; collaboration; block grant strategy, labor relations, marketing, fee-for-service.

(2) Practice Issues.

(3) Home health: collaboration and competition with proprietaries

(4) Allocation of federal and state dollars for health (block grants, channeling, funds for health promotion, marketing, etc)

(5) Establishing standards of practice - use population needs as a basis for health promotion and disease prevention.

RECOMMENDATIONS/STRATEGIES

For individual nurses and State-level nursing organizations:

(1) Get to the Governor and Legislative Committees, alone, with groups, and through friends of committee members; know what you need and be able to speak to it.

(2) Keep legislators educated and informed.

(3) Educate the consumers after you learn where they stand and what they know; form a consortium--know community leaders.

(4) Get all related health groups involved, including H.S.A.'s, unified on the issue.

(5) Try to learn where state and local tax dollars are going and whether anything remains--Is Health getting fair share or is more funding needed.

(6) Find clients, sell the service, and use private dollars. Industry is a potential funding source.

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(6) Find clients, sell the service, and use private dollars. Industry is a potential funding source.

(7) Present testimony; stimulate, promote public hearings; do it via a unified group who come well-prepared.

For MAIN:

(1) Establish a liaison with Midwest Governor's Group, National Council of State Governments, National Council of Mayors, etc.

(2) Use this group as a source of information among the MAIN states, letting states know how each achieved successes with funding, legislation, etc., and what problems were encountered.

(3) Gather data on cost effectiveness, cost-savings, and comparisons of related costs, in acute and chronic illnesses, and prevention vs. chronic disease.

(4) MAIN can collect and publish comparative data re: money saved via health care services of nurses.

CAUCUS GROUP IV: LICENSURE ISSUES

Leader: Shirley A. Ross, BSN, MPH

Priority issues:

(1) Practice Act:

a. revision to include expanded role

b. definition of competence.

c. standards for practice - i. measurable
ii. role of CE for relicensure

d. Scope of practice issues

(2) Regulation of nursing education programs - whose prerogative is it? How to implement National Credentialing Center for Nursing.
(3) Sunset laws and how to "deal" with them.
(4) Levels of licensure
(5) Composition of boards of nursing; appointment to Boards and how this affects decisions related to nursing.

In relation to regulation:

(1) Nurse faculty and nurse administrators need to be knowledgeable about and help to maintain standards.
(2) State Nursing Boards need to support education programs, set up Advisory Committee.
(3) Responsibility of alumnae to remain involved to assist with 1., 2. above.
(4) Set up shared appointments, work to improve clinical competence, credibility of faculty; educational development of clinical staff.
(5) Initiate legislation to foster improved nursing; and for improved public health.

For individual nurses:

In relation to the State Nurse Practice Act:

(1) Volunteer for Task Forces
(2) Help develop a talent bank
(3) Help clarify and resolve education issues

(4) Monitor legislation efforts.

For State-level nursing organizations:

(1) networking and collaboration among nursing, health, and consumer.

(2) collaboration with existing community groups

(3) nursing networks

(4) initiate legislation

(5) research data base

(6) workshop on legislative issues

(7) group meet prior to testifying

For MAIN:

(1) should be repository for names of individuals who volunteer for task forces.

(2) clearinghouse for successful projects and strategies.

(3) keep a tally of pertinent legislative decisions affecting nursing and report them in newsletter to all 13 states.

(4) recommend legislation to improve practice and patient care.

(5) could present regional workshops on utilization of legislative process.

Appendix A: A GUIDE TO LEGISLATIVE INFORMATION

The following information helps explain the legislative process, and the "how to's" of conducting research on issues, contacting legislators, and making your beliefs known.

LETTERS SENT TO CONGRESSMEN: (Note: Congressmen may receive as many as 30,000 pieces of mail per year regarding health issues.)

When letters reach the congressman's office, they are perused by an aide who determines the subject matter, and then files the communications according to the subject. When an issue related to the subject comes before Congress, the subject file is pulled; but before this time the communication generally receives no other attention than that given by the aide. In the meantime, the sender receives Form Letter 47 thanking her/him for writing.

Congressmen have Administrative Aides and Legislative Aides. Individuals or groups seeking to effect legislation or to lobby, generally communicate directly with the Legislative Aides, rather than the congressmen, because the Aides are the ones who do the researching and other related work to thoroughly prepare the subject for the congressmen.

To establish communication with the individual congressman (most likely through the Legislative Aide), one may plan as follows:

1. On the first trip to Washington, or to the State Legislator's office, drop by and say hello to the secretary, and leave your card.

2. On the next trip, call the secretary, introduce yourself and say "you remember me," and ask for an appointment (which will be with the Legislative Aide).

3. At the meeting, the "magic" length reported is 15 minutes. A positive sign of interest is the Aide taking notes.

HOW TO LEARN ABOUT AN ISSUE:

Research three areas on any given issue:

1. The background and demographic information
2. The funding sources
3. The people involved (opinions pro and con)

A Guide to Legislative Information

The above steps may be conducted simultaneously. The information gathering process will be ongoing throughout your involvement with an issue, and will be the basis for all lobbying or legislative contacts.

To begin, you will need to consult the general reference section at the public library for sources, and other libraries and/or information centers in your area that can provide additional information on the issues.

HOW TO DEFINE LEGISLATIVE TERMS:

Glossary for Effective Citizenship

Calendar - The list of the order in which legislation is to be considered in each house. As a verb it means to be put on the list.

Caucus - A meeting of members of one political party of a chamber of the legislature. They generally consider strategy or policy questions.

Conference Committee - Committee that agrees on a single text since bills must be passed in identical form by both houses.

Committee of the Whole - The whole chamber dissolved from its normal form to consider a specific matter. No vote can be taken.

Companion Bill - The term that applies to the Bills that are in the assembly and senate at the same time although they have different bill numbers.

Engrossed Bill - The form of the bill that includes all the adopted amendments present and read to one chamber for its third reading.

Enrolled Bill - The form of the bill after it has been passed in identical form by both chambers.

Indefinite Postponement - A committee or any member may recommend this when a bill is reported to the chamber. If the motion to postpone is passed, the bill is finally disposed of ("killed") in that chamber.

Joint Resolution - It is not a law-making move but rather to convey instructions, congratulations, etc. It does not require the Governor's signature.

Lobby - Promoting or opposing legislation before the legislature, legislators, or committees according to the statutes. Action to influence adoption, or amendment, or repeal of administrative rules is also generally included in the definition.

Substitute Amendment - Replaces original bill, if adopted, when proposed changes are numerous. May entirely change the effect of the original bill.

Pocket Veto - An indirect veto of a bill by not signing the bill and letting the legislature adjourn before the designated signing period.

ABBREVIATIONS:

A.S. - Assembly Speaker
H.B. - House Bill
H.R. - House of Representatives
J.R. - Joint Resolution
P.L. - Public Law
S.B. - Senate Bill
F.Y. - Fiscal Year

HOW TO DEVELOP CLOUT:

Once research on a topic is completed and you have become involved with your issue in a legislative capacity, you may wish to organize support for your issue with the various other interest groups.

ORGANIZE

- Get all interested parties together, interview people and organize for parallel concerns
- Get all members involved; put everyone in charge of something
- Develop leadership and membership skills; make training an ongoing part of your activities
- Research government requirements for citizens involvement in the issue-area which concerns you
- Set up and thoroughly define your goals

STRATEGIES AND FORMS OF INVOLVEMENT

- Decide which form of involvement or strategy would be more effective for your group
- Demand to be heard at the times you want; not just the times the decision makers invite you to speak
- Set up a demonstration or "alternative" project; decide how a problem should really be dealt with and show others how it ought to be done
- Canvas neighborhoods to gather opinions and build support
- Publicize desired changes through mass media
- Go directly to decision makers, develop strategies for bypassing uncooperative decision makers
- Evaluate your progress regularly and take whatever steps necessary to keep you headed toward your goal

IMAGE AND POSTURE

- Clarify your goals for improving your citizen participation mechanism: your access to power, to information, etc.
- Develop a more forceful image - a more vigorous stance or posture; assume that you have the power you would like and start acting as if you have it
- Develop a stance of initiating plans and policies rather than reacting to those of some government agency or other organization
- Launch a public education campaign, become a household word, enlist aid of mass media

HOW TO MAKE YOUR FEELINGS KNOWN:

Communication with Legislators

The three types of communication with your legislator are:

- Visits
- Hotline/calls
- Letters

Some are more effective than others, but all if done properly will have some effect. Choose the one most comfortable for you.

VISITS: Most effective method

- Make advance appointment
- Be on time
- Know your issue, know what you would like the legislator to do
- Know the Bill Number, who sponsored it, action taken on it
- Leave copies of points covered with Legislator, include your name and address
- Visit in small groups
- Always be courteous
- Allow your legislator to have his/her say
- Be as brief as possible (15 minutes), stick to one subject
- Convey impression that group is representative of larger numbers
- Unless you have something very new to say, visit once on an issue
- Send thank you letter after meeting

HOTLINE/CALLS: Most effective on Bills at Committee Level

- Refer to Bills by numbers, understand action already taken on bill
- State action you desire from your Legislator
- Request response from Legislator
- Understand that these calls will reach Legislator as a message

LETTERS: Most effective when timed according to Bill Status

- Address your Legislator properly (consult a reference book for correct forms of address)
- Be brief, clear and write legibly
- Discuss only one issue per letter; identify a bill number
- Use your own words and stationery
- Include your address on letter and envelope, sign name legibly
- Be courteous and reasonable
- Write when you have question/problem with procedures of government
- Write to say you approve - not just to complain
- In the first sentence, state the issue/bill and how you wish the legislator to vote
- Ask original questions in order to receive an original reply
- Write early before a bill has been introduced. If legislator is not a member of a committee handling bill write him/her just before the bill comes to the floor for debate/vote.

A FEW WARNINGS

- Do not send a postcard, form letter
- Do not begin "As a citizen and taxpayer"
- Do not apologize for writing/taking her/his time
- Do not be rude/threatening
- Do not be vague
- Do not send carbon copies to other legislators

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